5101:3-2-075 Disproportionate share adjustment.

This rule describes the disproportionate share definition and limitations on payment methods described in rule 5101:3-2-09 of the Administrative Code and assessment determinations described in rule 5101:3-2-08 of the Administrative Code for the program year SPECIFIED IN PARAGRAPH (A)(9) OF RULE 5101:3-2-08 ~~ending in calendar year 1998~~.

(A) For the program year SPECIFIED IN PARAGRAPH (A)(9) OF RULE 5101:3-2-08 ~~ending in calendar year 1998~~, paragraphs (B) to (D) of this rule set forth the definition of disproportionate share as well as other procedures and data used for the disproportionate share calculations and assessment determinations as described in rule 5101:3-2-08 of the Administrative Code and payment determinations as described in rule 5101:3-2-09 of the Administrative Code.

(B) ~~For the program year that ends in calendar year 1998,~~ The source data used for the calculations made in paragraphs (A) to (D) of this rule and in rules 5101:3-2-08 and 5101:3-2-09 of the Administrative Code will be the hospital's cost-reporting period ending in THE state fiscal year AS SPECIFIED IN PARAGRAPH (C) OF RULE 5101:3-2-08 ~~1997~~.

(C) Determination of disproportionate share qualification.

(1) For each hospital calculate the medicaid utilization rate by dividing total medicaid days as defined in paragraph (A)~~(22)~~ of rule 5101:3-2-09 of the Administrative Code by total facility days as defined in paragraph (A)~~(24)~~ of rule 5101:3-2-09 of the Administrative Code.

(2) Each hospital with a medicaid utilization rate greater than or equal to one per cent qualifies as a disproportionate share hospital for the purposes of rule 5101:3-2-09 of the Administrative Code.

(3) Each hospital with a medicaid utilization rate less than one per cent qualifies as a nondisproportionate share hospital for the purposes of rule 5101:3-2-09 of the Administrative Code.

(D) Limitations on disproportionate share and indigent care payments made to hospitals ~~effective for state fiscal year 1998~~.

(1) For each hospital, calculate medicaid shortfall by subtracting from total medicaid costs, as defined in paragraph (A)~~(1)~~ of rule 5101:3-2-09 of the Administrative Code, total medicaid payments as described in paragraph (A)~~(21)~~ of rule 5101:3-2-09 of the Administrative Code. For those hospitals exempt from the prospective payment system as described in Rule 5101:3-2-071 of the Administrative Code, medicaid shortfall equals zero.

(2) For each hospital, determine the total cost of uncompensated care for people without insurance as described in paragraphs (D)(2)(a) to (D)(2)(e) of this rule.

(a) For each hospital, "total inpatient uncompensated care charges for people without insurance" means the sum of the inpatient disability assistance medical charges, uncompensated care charges below the poverty level, and

uncompensated care charges above the poverty level amounts from the ODHS 2930, schedule F~~, column 2, lines 8, 9, and 10~~.

(b) For each hospital, calculate the total inpatient uncompensated care costs for people without insurance by multiplying total inpatient uncompensated care charges as defined in paragraph (d)(2)(a) of this rule times the inpatient medicaid cost to charge ratio as described in paragraph (A)~~(26)~~ of rule 5101:3-2-09 of the Administrative Code.

(c) For each hospital, "total outpatient uncompensated care charges for people without insurance" means the sum of the outpatient disability assistance medical charges, uncompensated care charges below the poverty level, and uncompensated care charges above the poverty level amounts from the ODHS 2930, schedule F~~, column 2, lines 12, 13, and 14~~.

(d) For each hospital, calculate the total outpatient uncompensated care costs for people without insurance by multiplying total outpatient uncompensated care charges as defined in paragraph (D)(2)(c) of this rule times the outpatient medicaid cost to charge ratio as described in paragraph (A)~~(27)~~ of rule 5101:3-2-09 of the Administrative Code.

(e) For each hospital, total uncompensated care costs for patients without insurance is equal to the sum of paragraphs (D)(2)(b) and (D)(2)(d) of this rule.

(3) For each hospital, calculate medicaid outpatient radiology services shortfall as described in paragraphs (D)(3)(a) to (D)(3)(e) of this rule.

(a) Using the medicaid claims payment system as the source of data, determine total charges for outpatient radiology procedures, for each hospital, for the time period corresponding to each hospital's fiscal year ending in THE state fiscal year AS SPECIFIED IN PARAGRAPH (C) OF RULE 5101:3-2-08 ~~1997~~.

(b) Using the medicaid claims payment system as the source of data, determine total payments for outpatient radiology procedures, for each hospital, for the time period corresponding to each hospital's fiscal year ending in THE state fiscal year AS SPECIFIED IN PARAGRAPH (C) OF RULE 5101:3-2-08 ~~1997~~.

(c) For each hospital, calculate the hospital specific outpatient cost to charge ratio by dividing total medicaid outpatient costs as reported in the ODHS 2930~~, schedule H, section H, column 1, line 13~~ by total medicaid outpatient charges as reported in the ODHS 2930, AS DESCRIBED IN PARAGRAPH (A) OF RULE 5101:3-2-09 ~~schedule H, section H, column 1, line 20~~.

(d) For each hospital, determine total medicaid outpatient radiology costs by multiplying the ratio calculated in paragraph (D)(3)(c) by the amount in paragraph (D)(3)(a) of this rule.

(e) For each hospital, total medicaid outpatient radiology shortfall is equal to the amount in paragraph (D)(3)(d) minus the amount in (D)(3)(b) of this rule .

(4) For each hospital, calculate the hospital disproportionate share limit by adding the medicaid shortfall as described in paragraph (D)(1) of this rule, total uncompensated care costs for people without insurance as described in paragraph (D)(2)(e) of this rule, and outpatient radiology shortfall as described in paragraph (D)(3)(e) of this rule.

(5) The hospital will receive the lessor of the disproportionate share limit as described in paragraph (D)(4) of this rule or the disproportionate share and indigent care payment as calculated in rule 5101:3-2-09 of the Administrative Code.

Effective Date: _____

RC 119.032 review dates: _____

Certification: _____

_____
Date

Promulgated Under RC Chapter 119.

Statutory Authority RC Section 5111.02, 5112.03

Rule Amplifies RC Sections 5111.01, 5111.02, 5112.01 to 5112.21

Prior Effective Dates: 10/19/87, 7/1/88 (Emer.), 9/29/88, 7/2/92 (Emer.), 9/20/92, 7/16/93 (Emer.), 9/30/93, 7/24/94, 3/10/95 (Emer.), 5/18/95, 3/16/96, 8/7/96 (Emer.), 10/21/96, 8/25/97 (Emer.), 11/1/97,8/6/98 (Emer.), 9/18/98

5101:3-2-076 Capital Costs.

(A) For purposes of this rule, capital costs include the categories of costs recognized by medicare on the HCFA 2552-96 ~~2552-85~~.

(B) ~~Effective with the date of this rule, capital-related~~ CAPITAL-RELATED costs for Ohio hospitals paid under prospective payment will be subject to reasonable cost reimbursement. ~~Cost settlement of capital costs for the hospital's fiscal year during which this rule takes effect will be achieved by dividing the medicaid inpatient portion of total reimbursable capital costs by twelve and multiplying the result by the number of months during the fiscal period that this rule was in effect.~~ The ~~resulting~~ program reimbursable amount will be reconciled during settlement to the total amount of interim capital payments associated with discharges occurring during the ~~portion of the~~ cost-reporting period ~~that this rule was in effect~~.

(C) ANNUAL UPDATE OF INTERIM CAPITAL PAYMENTS

~~For the prospective rate year beginning with the effective date of this rule, the~~ THE calculation of interim capital payments resulting in the capital allowance identified in paragraph (I) of rule 5101:3-2-074 of the Administrative Code are based on ~~either~~ the hospital's ~~1985 or 1986~~ cost-reporting period. ~~The payments are calculated using the following methodology:~~

~~(1) For hospitals with a calendar fiscal year, the capital-related cost amount is determined using their 1985 cost report. For fiscal year hospitals, the capital-related cost amount is determined using their 1986 cost report (cost-reporting period ending in 1986). For those hospitals with fiscal year ending September thirtieth or October thirty-first, the capital-related cost amount is determined using the cost report reflecting an ending date in ¶985. For hospitals having a March thirty-first, May thirty-first, and August thirty-first fiscal year-end date, the cost amount is determined using the cost report reflecting an ending date in 1986.~~

~~(2) The capital-related costs as described in paragraphs (D)(8) to (D)(8)(b) of rule 5101:3-2-074 of the Administrative Code are divided by the number of discharges used to compute the average cost per discharge as described in rule 5101:3-2-074 of the Administrative Code.~~

~~(D) Annual update of interim capital payments.~~

HCFA-179 # 00-008 Date Rec'd
Supercedes Date Appr. SEP 11 200
State Rep. In Date Eff.

ON AN ANNUAL BASIS ~~In subsequent years~~, the interim capital payments will be redetermined by identifying the capital-related costs reported on HCFA 2552-96 ~~2552-85~~; multiplying that cost by the per cent of medicaid inpatient charges to total charges; and dividing the result by the number of medicaid discharges that occurred during the cost-reporting period. The cost reports used to complete these calculations are those identified in paragraphs (C)~~(D)~~(1) and (C)~~(D)~~(2) of this rule.

(1) For hospitals with fiscal periods ending JULY THIRTY-FIRST, AUGUST THIRTY-FIRST, September thirtieth, October thirty-first, or December thirty-first, the cost report for the period ending in the calendar year preceding the calendar year which precedes the upcoming prospective rate period is used.

(2) For hospitals with fiscal periods ending March thirty-first, May thirty-first, OR June thirtieth, ~~or August thirty-first~~, the cost report for the period ending in the fiscal year preceding the upcoming rate period is used.

(D)~~(E)~~Non-Ohio hospital capital reimbursement.

(1) The average statewide capital cost is computed by summing total capital costs for all Ohio hospitals as described in paragraph (C)~~(2)~~ of this rule, divided by total discharges for all Ohio hospitals as described in paragraph (C)(2) of this rule.

(2) The average statewide capital cost is updated annually using capital costs from cost reports as described in ~~paragraphs~~ PARAGRAPH (C)~~(D) to (D)(2)~~ of this rule.

(3) The amounts derived in paragraph (D)~~(E)~~(1) of this rule will reflect a statewide average calculated to be in effect at the beginning of the prospective rate year and not subject to retrospective adjustments.

Effective Date: June 19, 2000

Review Dates: 31 MARCH 2000, 31 MARCH 2005

Certification: _____

_____
Date

Promulgated under RC Section 119.03
Statutory Authority RC Section 5111.02
Prior Effective Dates: 10/1/84, 7/4/85, 7/3/86, 10/19/87

5101:3-2-077 Medical education.

Ohio hospitals that have an approved medical education program as defined in 42 CFR 413.86 ~~405.421~~ qualify for an allowance for medical education. This rule describes the method used to determine the medical education allowance that will be added to the DRG base price for teaching hospitals. Source documents used are those described in paragraph (D) of rule 5101:3-2-074 of the Administrative Code.

(A) Direct medical education allowance.

(1) Identify the hospital's intern and resident cost as reported on the HCFA 2552-85, worksheet B, part I, line 95, column 21 and divide that cost by the number of full-time equivalent (FTE) residents and interns reported by the hospital on HCFA 2552, worksheet S-3, column 9, lines 8, 9, and 10.

(2) Determine the value of one standard deviation above the statewide mean cost per intern/resident. The statewide mean cost per intern/resident is determined by dividing the statewide total cost for interns and residents by the total number of FTE interns and residents in the state. The numbers used in this computation are identified in paragraph (A)(1) of this rule.

(3) Compare the hospital-specific average cost per intern/resident as described in paragraph (A)(1) of this rule with the amount derived from paragraph (A)(2) of this rule. The allowable cost per intern/resident for hospitals which have a hospital-specific average cost per intern/resident below the amount derived from paragraph (A)(2) of this rule is the amount derived as described in paragraph (A)(1) of this rule. The allowable cost per intern/resident for hospitals which have a hospital-specific average cost per intern/resident above the amount derived from paragraph (A)(2) of this rule is the amount as described in paragraph (A)(2) of this rule.

(4) Multiply the hospital's allowable cost per intern/resident, as described in paragraph (A)(3) of this rule, by the hospital's number of FTE interns and residents.

(5) Add to the total allowed cost for interns and residents computed in paragraph (A)(4) of this rule, the hospital's costs for nursing and paramedical education from HCFA 2552-85, worksheet B, line 95, columns 20, 22, 23, and 24.

(6) Multiply the total allowed direct medical education cost derived in paragraph (A)(5) of this rule by the per cent derived in paragraph (D)(6)(b)(iii) of rule 5101:3-2-074 of the Administrative Code. Divide this product by the number of discharges used to calculate the average cost per discharge as described in rule 5101:3-2-074 of the Administrative Code.

(B) Indirect medical education allowance.

(1) The hospital's indirect medical education percentage will be determined by applying the following logarithmic formula:

$$2\left[X\left(\frac{1+\text{Residents}}{\text{Beds}}\right)^{.405}-1\right]$$

The number of interns and residents will be the number described in paragraph (A)(1) of this rule. The number of beds will be the number reported on HCFA 2552, worksheet S-3, lines 8, 9, and 10, column 1.

(2) Determine the total indirect medical education cost for a hospital by subtracting the amount derived in paragraph (D)(9)(c) of rule 5101:3-2-074 of the Administrative Code from the amount derived in paragraph (D)(8)(e) of rule 5101:3-2-074 of the Administrative Code.

(3) Determine a hospital-specific unit cost of indirect medical education by dividing the amount derived from paragraph (B)(2) of this rule by the product of one hundred times, the percentage calculated in paragraph (B)(1) of this rule. This amount is then divided by the number of discharges used to calculate the average cost per discharge as described in rule 5101:3-2-074 of the Administrative Code.

(4) A statewide mean unit cost for indirect medical education is determined by summing all hospitals' unit cost as described in paragraph (B)(3) of this rule, eliminating the two values that represent the highest and the lowest values, and dividing this sum by the number of values used in this calculation. The values of one standard deviation above this statewide mean cost is then determined.

(5) Compare the hospital-specific unit cost of indirect medical education as described in paragraph (B)(3) of this rule to the statewide mean unit cost plus one standard deviation as described in paragraph (B)(4) of this rule. The allowable indirect medical education unit cost for hospitals which have a hospital-specific unit cost below the statewide mean plus one standard deviation is the amount derived in paragraph (B)(3) of this rule. The allowable unit cost for hospitals with a unit cost above the statewide mean plus one standard deviation is the amount derived in paragraph (B)(4) of this rule.

(6) The allowable unit cost for indirect medical education is multiplied by one hundred, times the indirect medical education percentage described in paragraph (B)(1) of this rule to determine the indirect medical education allowance.

(C) The total medical education allowance is the sum of the indirect medical education allowance derived in paragraph (B)(6) of this rule and the direct medical education amount derived in paragraph (A)(6) of this rule, adjusted for inflation as described in paragraphs (D)(12)(e), (G)(1), and (G)(2) of rule 5101:3-2-074 of the Administrative Code.

(D) THE TOTAL MEDICAL EDUCATION ALLOWANCE AS DESCRIBED IN PARAGRAPH (C) OF THIS RULE IS ADJUSTED TO REMOVE THE EFFECTS OF THE HOSPITAL'S CASE MIX. THE DATA USED TO COMPUTE THE HOSPITAL'S CASE MIX INDEX ARE THE HOSPITAL'S CLAIM RECORDS FOR DISCHARGES OCCURRING DURING THE HOSPITAL'S FISCAL PERIOD, ON OR AFTER APRIL 1, 1990 THROUGH DECEMBER 31, 1991, AND PAID BY DECEMBER 31, 1992. FOR PURPOSES OF THIS PARAGRAPH, CASE MIX IS DETERMINED USING THE DRG CATEGORIES AND RELATIVE WEIGHTS DESCRIBED IN RULE 5101:3-2-073 OF THE ADMINISTRATIVE CODE AND INCLUDES OUTLIER CASES AS DESCRIBED IN RULE 5101:3-2-079 OF THE ADMINISTRATIVE CODE.

(1) FOR EACH HOSPITAL THE NUMBER OF CASES IN EACH DRG IS MULTIPLIED BY THE RELATIVE WEIGHT FOR EACH DRG. ROUND THE RESULT TO FIVE DECIMAL PLACES. THE RELATIVE WEIGHTS ARE THOSE DESCRIBED IN RULE 5101:3-2-073 OF THE ADMINISTRATIVE CODE.

(2) SUM THE RESULT OF EACH COMPUTATION IN PARAGRAPH (D)(1) OF THIS RULE.

(3) DIVIDE THE PRODUCT FROM PARAGRAPH (D)(2) OF THIS RULE BY THE NUMBER OF CASES IN THE HOSPITAL'S SAMPLE AS DESCRIBED IN PARAGRAPH (D) OF THIS RULE. ROUND THE RESULT TO FIVE DECIMAL PLACES. THIS PRODUCES A HOSPITAL-SPECIFIC CASE MIX INDEX.

(4) DIVIDE THE TOTAL MEDICAL EDUCATION ALLOWANCE AS DESCRIBED IN PARAGRAPH (C) OF THIS RULE BY THE HOSPITAL-SPECIFIC CASE MIX INDEX COMPUTED IN PARAGRAPH (D)(3) OF THIS RULE TO DETERMINE THE ADJUSTED TOTAL MEDICAL EDUCATION ALLOWANCE. ROUND THE RESULT TO THE NEAREST WHOLE PENNY.

(E) THE ADJUSTED TOTAL MEDICAL EDUCATION ALLOWANCE AS DESCRIBED IN PARAGRAPH (D) OF THIS RULE IS MULTIPLIED BY THE RELATIVE WEIGHT APPROPRIATE TO THE DRG AS DESCRIBED IN RULE 5101:3-2-073 OF THE ADMINISTRATIVE CODE, ROUNDING THE RESULT TO THE NEAREST WHOLE PENNY, TO DETERMINE THE HOSPITAL SPECIFIC MEDICAL EDUCATION ALLOWANCE AMOUNT FOR THE DRG.

Effective Date: JAN 20 1995

Certification: Arnold R. Tompkins

JAN 10 1995
Date

romulgated Under Chapter 119.

:atutory Authority RC Section 5111.02

le Amplifies RC Sections 5111.01 and 5113

ior Effective Dates: 10/4/84, 7/1/85, .

TN No. 95-11 APPROVAL DATE

SUPERSEDES

TN No. 82-45 EFFECTIVE DATE 1-2